

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05189

05187

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Rt #1, Box 302</u>	
3. NAME OF DECEASED (Type or print) <u>Walter William Ash</u>		4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Ash</u>		14. MOTHER'S MAIDEN NAME <u>Mary Presbury</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-54-7000T</u>	
17. INFORMANT <u>Mrs. Carrie Ash, Harre-de-Grace, Md.</u>		Address <u>Rt #1 Box 302</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>A.S.C.V.D.</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>? year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus + Malnutrition</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (i) (this hospital) attended the deceased from <u>4-19, 1967</u> to <u>4-26, 1967</u> , that (i) (we) last saw the deceased alive on <u>4-26, 1967</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>4/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harre-de-Grace, Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 30, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. James A.M.E. Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Harford Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Helene J. Bullock</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Harre-de-Grace, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 5 1967</u>		DATE <u>MAY 5 1967</u>	

02183

02183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and in any event within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05190					05188				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Harford</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
<u>HAURE DE GRACE</u> 2 days					<u>Bel Air</u> - 12.1 RURAL				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
<u>Harford Memorial Hosp.</u>					<u>Allibone Rd. (RFD#1, Box#224)</u>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <u>John</u> Middle <u>Fielder</u> Last <u>Black</u>					Month <u>April</u> Day <u>29</u> Year <u>1967</u>				
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
<u>MALE</u>	<u>WHITE</u>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	<u>Oct. 5, 1890</u>	<u>76</u> yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>			<u>Agriculture</u>		<u>Grayson Co., Virginia</u>			<u>U.S.A.</u>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
<u>Daniel Black</u>					<u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT (Son) B38-3269		Address			
<u>NO</u>		<u>218-14-7122 A</u>		<u>Mr. Harry L. Black</u>		<u>224#1, Box#224 Bel Air, Maryland 21014</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>									<u>2 days</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive and Arteriosclerotic</u>									
DUE TO (c) <u>Cardiovascular Disease</u>									<u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED?
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. <u>19</u>			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from <u>April 27, 1967</u> to <u>April 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 29, 1967</u> , and that death occurred at <u>1:40</u> M. from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
<u>Edward C. Loo</u>					<u>April 29, 1967</u>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
<u>Edward C. Loo, M.D.</u>					<u>Haure de Grace, Ind.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
<u>Burial</u>			<u>May 1, 1967</u>		<u>Bel Air Memorial Gardens</u>		<u>Bel Air, Harford Co., Maryland 21014</u>		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
<u>Joseph William Foster</u>					<u>Charles Judge</u>				
ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>					DATE <u>MAY 2 1967</u>				

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05191

05189

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Rochelle</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Rochelle</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Doa Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>49-3 Mt Joy Place</u>	
3. NAME OF DECEASED (Type or print) <u>Lee Evelyn C. Brown</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-41</u>
9. AGE (in years lost birthday) <u>25</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	
11. BIRTHPLACE (State or foreign country) <u>Robeson County, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willie Christian</u>		14. MOTHER'S MAIDEN NAME <u>Lucille Small</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Willie Christian, Laurinburg, N.C.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>8254</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Auto Acc. & ent</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4-10</u> o.m. <u>1967</u> p.m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 7</u>	20f. (City or town) (County) (State) <u>Hartford Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer M.D.</u>		22. DATE SIGNED <u>4-10-67</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Maxton N.C.</u>
24. FUNERAL DIRECTOR <u>Elmer E Bellink</u>		25. REC'D BY REGISTRAR <u>APR 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

62160

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05192						05190					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
HARFORD			D.O.A.			Maryland			HARFORD		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
HARFORD Memorial Hospital			J.O.A.			HAURE de GRACE			RT. 155 STAR Route		
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			e. IS RESIDENCE ON A FARM?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
First Middle Last			Month Day Year								
James HERMAN Clow			April 26 1967								
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MAR. 6 1909		58 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
SUPERVISOR PEOPLE PERSONNEL				RETIRED				PA.			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
JAMES H. CLOW SR.						EMILY VIOLA SARIVER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address					
				214-33-2042		DOLLY R. CLOW, HARFORD, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										9 hr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										8 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Cerebral Arteriosclerosis & Ischemia											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 11-12-62, 19 to 11-26-1967, that (I) (we) last saw the deceased alive on April 26, 1967, and that death occurred at 3:45 PM, from the causes and on the date stated above.											
22a. SIGNATURE						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
Peter P. Rodman, M.D.						22c. ADDRESS			4-27-67		
22c. PHYSICIAN'S NAME (Type)						Haverde Grace, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL				APRIL 29 1967		SUDERSVILLE CEM.		SUDERSVILLE MD			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
R. Madison Mitchell Haverde Grace, Md.						MAY 1 1967		J. Charles Judge			

02120

02120

MAY 1 1967

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05191

FOR STATE HEALTH DEPT.

05193

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF BIRTH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>27 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 121			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rte 1</u>				d. STREET ADDRESS <u>309 S. Main St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Olive M. Cullum</u>				4. DATE OF DEATH Month Day Year <u>April 5 1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 16, 1910</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>STREET, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ARCHER W. CULLUM</u>				14. MOTHER'S MAIDEN NAME <u>LAVINIA BULL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>45-32-285</u>		17. INFORMANT Address <u>Mrs. VERNON SMITH, STREET, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Breast with Metastases</u> DUE TO (b) <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Baltimore, Md.</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>4-5-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR. 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DUBLIN SOUTHERN</u>		23d. LOCATION (City or Town) (County) (State) <u>DUBLIN, HARTFORD, MD.</u>	
FUNERAL DIRECTOR <u>John H. Harkin, DELTA, PA.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Olive A. C. H. v. 10

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05194

CERTIFICATE OF DEATH

05192

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
c. LENGTH OF STAY in 1b <u>33 hrs.</u>		d. STREET ADDRESS <u>Susquehanna Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Addie Virginia Cunningham</u>		4. DATE OF DEATH Month Day Year <u>4 9 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 4, 1881</u>
9. AGE (In years last birthday) yrs <u>86</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (Country & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward</u>		14. MOTHER'S MAIDEN NAME <u>Martha Dye</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Helen C. Gillespie, Perryville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>A.S.C.V.D</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>old age</u> DUE TO (c) <u>old age</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>43 4-9 67</u>
21. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> , 19 <u>67</u> to <u>4-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-9</u> , 19 <u>67</u> , and that death occurred at <u>9:20</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Yuen</u>		22b. DATE SIGNED <u>4/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John D. Yuen</u>		22d. ADDRESS <u>Harpe-de-Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>April 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Maryland.</u>
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son, Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 17 1967</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

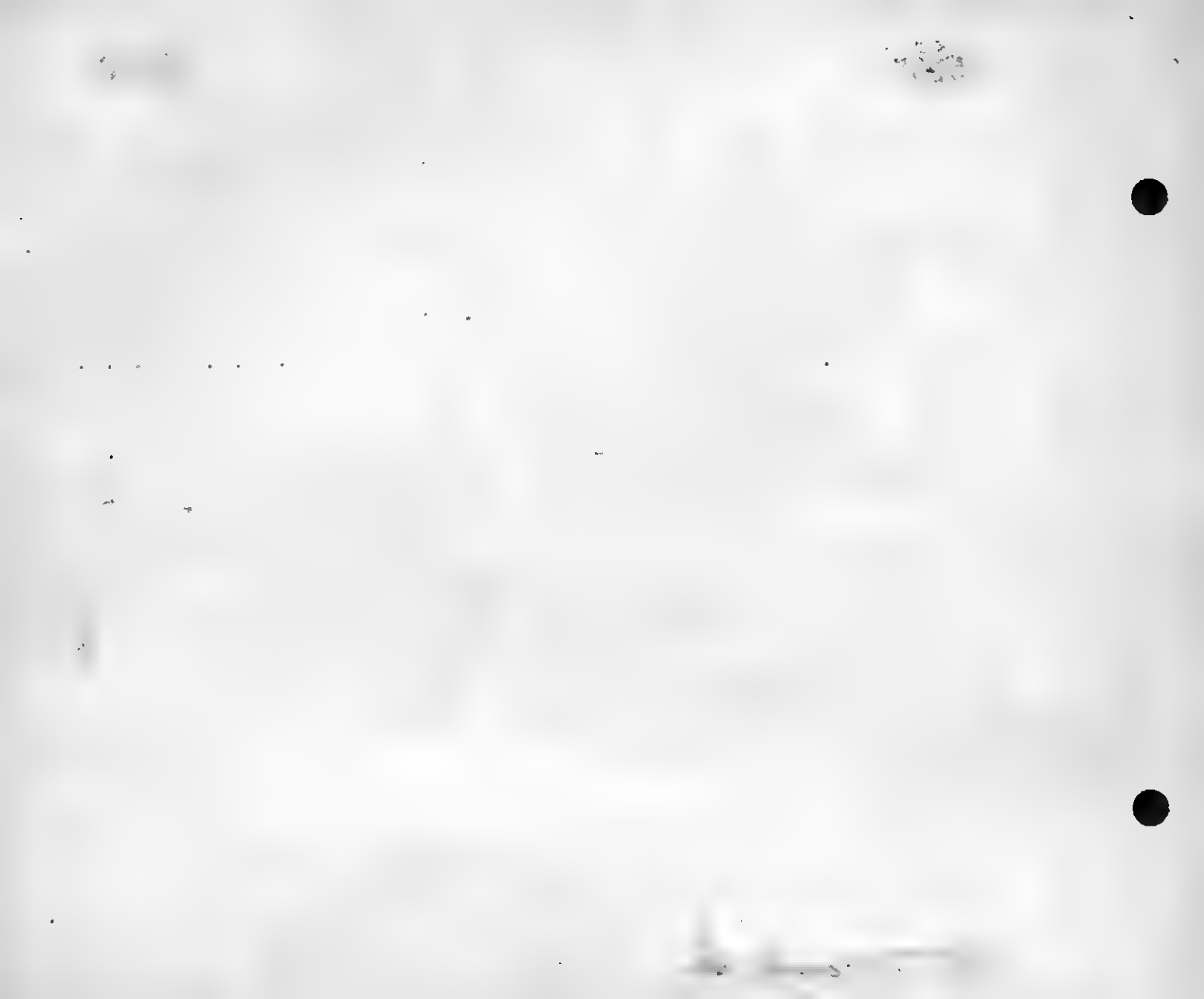
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05195						05193					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Hartford			Hartford			New York			Queens		
c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
Hartford			Astoria Long Island			33-03 24th Ave.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
MARIE Elizabeth Dolan						April 20 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 1, 1903		63 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Billing Dept. Clerk				General Motors				New York City, N.Y.		U.S.A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
John Berrill (D)						Elizabeth Flynn (D)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
No				050-22-4367		James Dolan				same as 2 C & D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 581.0 Bleeding Esophageal Varices											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the liver & portal											
(c) Hypertension											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (1) (this hospital) attended the deceased from 18 April, 1967, to 20 April, 1967, that (1) (we) last saw the deceased alive on April 20, 1967, and that death occurred at 8:30 M, from the causes and on the date stated above.											
22a. SIGNATURE						M.D. ATTENDING PHYS.			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			22b. DATE SIGNED		
W.H. SADOWSKY						504 Lewis St. Hamlet, N.Y.			4/20/67		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Removal			21 Apr. 67		Calvary Cemetery			Long Island City, N.Y.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Tarring Funeral Home						Aberdeen, Md.			APR 24 1967		



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05196					05194				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Street</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>					d. STREET ADDRESS <u>RD 2 Box 330</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>LESLIE</u> Last <u>EPPErley</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1967</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1910</u>		9. AGE (in years last birthday) <u>56</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beverage</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pilot, Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Posey Everett Epperley</u>				14. MOTHER'S MAIDEN NAME <u>Arinda Claradel Hall</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-18-5214</u>		17. INFORMANT <u>RD 2 Address Box 330 Clara M. Epperley Street, Md. 21154</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, recurrent</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular</u> DUE TO (c) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 2nd, 1967</u> to <u>April 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 18th, 1967</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/18/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				22d. ADDRESS <u>Haure de Grace, Ind.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/21/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nazarene</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air, Maryland</u>			
24. FUNERAL DIRECTOR <u>Charles E. Kurtz Jarrettsville, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE APR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05197

CERTIFICATE OF DEATH

05195

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>351 Wilson St</u>	
3 NAME OF DECEASED (Type or print) <u>Ruth Marie Perwood</u>		4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11 BIRTHPLACE (County & State, or foreign country) <u>71.24</u>		12 CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Peter Paul Gsick</u>		14. MOTHER'S MAIDEN NAME <u>Mary Heary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>unk.</u>	
17. INFORMANT <u>Frank Perwood</u> Address <u>41 Major Drive, Pikesville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> DUE TO <u>Hypertensive and Arteriosclerotic Cardiovascular Disease</u> (b) <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>443X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) <u></u>	
20c. TIME OF INJURY Month, Day, Year hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-27, 1967</u> to <u>4-29, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-29, 1967</u> and that death occurred at <u>8:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo</u> M.D.		22b. DATE SIGNED <u>4/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Hartford-de-Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Forest Hill, Md.</u>
24. FUNERAL DIRECTOR <u>James H. Hurd</u> ADDRESS <u>Harford, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

05198

CERTIFICATE OF DEATH

05196

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN 1b <u>7 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		e. STREET ADDRESS <u>CHESTNUT HILL RD</u>	
3. NAME OF DECEASED (Type or print) <u>MORRIS</u> First <u>O.</u> Middle <u>FORWOOD</u> Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 13, 1880</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>FOREST HILL, MD.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>PARKER L. FORWOOD</u>		15. MOTHER'S MAIDEN NAME <u>JULIA SMITHSON</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>10221</u>	
18. CAUSE OF DEATH (Enter only one cause per age for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Cardiac Decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>2-3 years</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 28, 1967</u> , to <u>APRIL 3, 1967</u> that (I) (we) last saw the deceased alive on <u>APRIL 3, 1967</u> , and that death occurred at <u>10:04</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loe, M.D.</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loe, M.D.</u>		22d. ADDRESS <u>HAVERDE GRACE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR. 5, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>DEER CREEK METHODIST</u>		23d. LOCATION (City or Town) (County) (State) <u>CHESTNUT HILL, HARFORD, MD.</u>	
24. FUNERAL DIRECTOR <u>John N. Harkins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR <u>APR 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05199

CERTIFICATE OF DEATH

05197

1 PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b <i>3 mo.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Brevin Nursing Home</i>		d. STREET ADDRESS <i>Perryville</i>	
3 NAME OF DECEASED (Type or print) <i>Naomi</i> First <i>K.</i> Middle <i>Fouche</i> Last		4. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>67</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>Cau.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 31, 1897</i>
9 AGE (In years last birthday) <i>69</i> yrs		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11 BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Kelly</i>		14. MOTHER'S MAIDEN NAME <i>Clara McMullen</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>219-05-7793</i>	
17. INFORMANT <i>Miss Ethel Taylor, Perryville, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>334X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Sclerosis -</i> (c) <i>Arterio Sclerosis -</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 mos -</i> <i>5 yrs -</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arterio Sclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 20, 1964</i> to <i>April 27, 1967</i> , that (I) (we) lost saw the deceased alive on <i>April 28, 1967</i> , and that death occurred at <i>11:20 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Clarence I. Benson</i>		22b. DATE SIGNED <i>4/29/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Clarence I. Benson</i>		22d. ADDRESS <i>Port Deposit, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 2, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Asbury Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Port Deposit Cecil Md.</i>	
24 FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>3 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10/10/10

10/10/10



05200

CERTIFICATE OF DEATH

05198

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		d. STREET ADDRESS <u>623 N. Stokes St.</u>	
3 NAME OF DECEASED (Type or print) <u>Alonza Byer Frederick</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Municipal Utilities</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Harde Chase, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John N. Frederick (dec)</u>		14. MOTHER'S MAIDEN NAME <u>Maudie M. Walker (dec)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>+</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT <u>Wilbur Frederick</u>		Address <u>623 N. Stokes St. Harde Chase Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interseptal Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular</u> DISEASE (c) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 years</u>	
PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cirrhosis of the liver</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1st, 1967</u> to <u>April 2, 1967</u> that (I) (we) last saw the deceased alive on <u>April 2, 1967</u> , and that death occurred at <u>11 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Lee, M.D.</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>		22d. ADDRESS <u>Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/6/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d. LOCATION (City or town) (County) (State) <u>Harde Chase Md</u>	
24 FUNERAL DIRECTOR <u>Barroughs, Rm. Harde Chase Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>APR 10 1967</u>	

100



100

05201

CERTIFICATE OF DEATH

05199

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Resident before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 419 Baltimore Street		d. STREET ADDRESS 419 Baltimore Street	
3. NAME OF DECEASED (Type or print) First AQUILLA Middle FRISBY Last FRISBY		4. DATE OF DEATH Month April Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1897
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Post Office Dept. Harford County, Md.	
11. BIRTHPLACE (County & State or foreign country) USA.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME George Frisby (D)		14. MOTHER'S MAIDEN NAME Harriett Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO 219-05-0930	
17. INFORMANT Hazel Frisby, Aberdeen, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO ASHD CONDITIONS if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD DUE TO ASCVD (c)		INTERVA. BETWEEN ONSET AND DEATH YEARS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from DEC. 1966 to APRIL 1967 , that (I) (we) lost the deceased alive on 4/14 1967 , and that death occurred at 8:40 AM on the date stated above.			
22a. SIGNATURE Santiago Leyte-Vidal		22b. DATE SIGNED 4/25/67	
22c. PHYSICIAN'S NAME (Type) Santiago Leyte-Vidal M.D.		22d. ADDRESS 114 W. Bel Air, Aberdeen, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 27 April 67	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	23d. LOCATION (City or Town) (County) (State) Aberdeen, Maryland
24. FUNERAL DIRECTOR Walter Macomber Jr.		25a. REC'D BY REGISTRAR Tarring Funeral Home	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 27 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05202

CERTIFICATE OF DEATH

05200

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford-de-Grace</u>		c. LENGTH OF STAY IN lb. <u>17 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>RD # 3</u>	
3 NAME OF DECEASED (Type or print) <u>Mamie Ramsey Gregg</u>		4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
11. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Ramsey</u>		14. MOTHER'S MAIDEN NAME <u>Allie Ewing</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Wilhelmina Gregg (Son)</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia of right upper</u> DUE TO <u>lower lobes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>_____</u> DUE TO (c) <u>_____</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized atherosclerosis + A.S.C.V.D. + CVA.</u>			
18a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	19b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	19d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-5</u> , 19 <u>67</u> to <u>4-6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/6</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> PM, from causes and on the date stated above			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>4/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harford-de-Grace, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moore's Chapel Cemetery, Blake, Cecil Co. Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Hicks Home for Funerals, Elkton, Md.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05203

CERTIFICATE OF DEATH

05201

1 PLACE OF DEATH a COUNTY <u>HARFORD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>139 Maulsby Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>WALTER JAMES HASH, JR.</u>		4 DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 4 1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	9. AGE (In years last birthday) yrs. <u>3</u> Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>
11 BIRTHPLACE (County & State, or foreign country) <u>md</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter James Hash</u>		14. MOTHER'S MAIDEN NAME <u>Mary Evelyn McGreevy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT (Father) <u>Mr. Walter James Hash</u>		Address <u>139 Maulsby St Bel Air, Maryland 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute cerebral edema</u> 760.0 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hemorrhage from Rt. ventricular tear</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 4, 1967</u> to <u>APRIL 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>APRIL 7, 1967</u> , and that death occurred at <u>9:30 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u></u>		22d. ADDRESS <u></u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Harford Co., Maryland</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>	
DATE <u>APR 11 1967</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

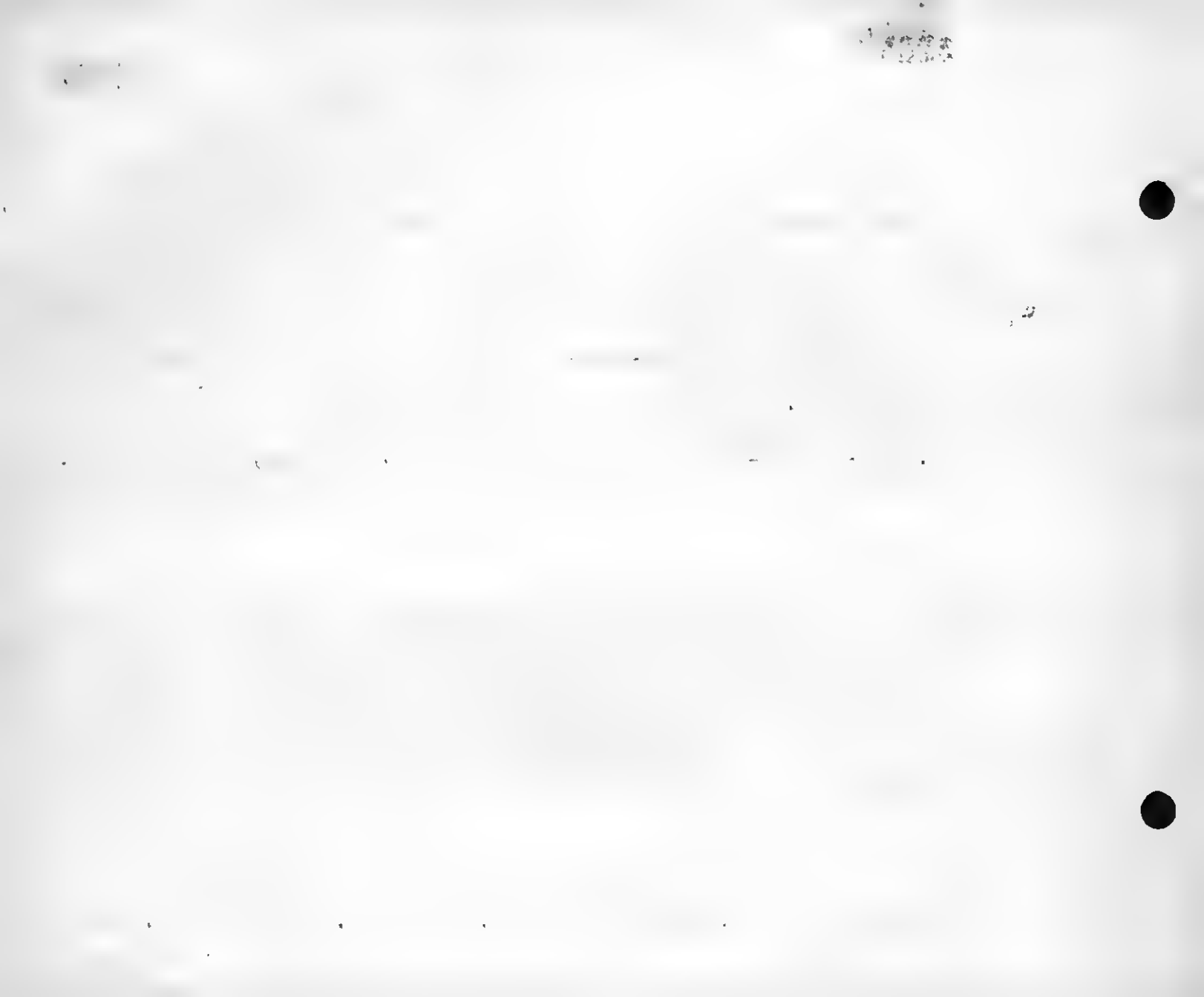
CERTIFICATE OF DEATH

05204

05202

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Perryville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Market & Cer. St. Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville, Md</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Reservoir Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>L. H. Hornberger</u>		4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/73</u>
9. AGE (In years last birthday) <u>13</u> yrs		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>6</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry M. Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Smeltzer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Medicare # 220-46-2400 T</u>	
17. INFORMANT <u>Paul A. Patterson</u>		Address <u>Perryville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> DUE TO (b) <u>ASCVD</u> DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>4/24/67</u> , 19 <u>67</u> , to <u>4/26/67</u> , 19 <u>67</u> , that (1) (we) lost saw the deceased alive on <u>4/26/67</u> 19 <u>67</u> , and that death occurred at <u>11:03</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles Judge MD</u>		22b. DATE SIGNED <u>4/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. W. GRIEGLER MD</u>		22d. ADDRESS <u>HARVRE d. GRACE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>April 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Patterson Fam. Burial Gds.</u>	23d. LOCATION (City or Town) (County) (State) <u>Perryville, Md. Cecil</u>
24. FUNERAL DIRECTOR <u>Charles Judge</u>	25a. REC'D BY REGISTRAR <u>MAY 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

VR A15 (4)
25M 1/67



1
10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05203					05203						
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE						
Harford					Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b						
Aberdeen Proving Ground					3 Days						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. STREET ADDRESS						
Kirk Army Hospital					1001 Old Joppa Road						
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			William		H. B.		HOWARD		Month Day Year April 9 1967		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		18 February 1904		63 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Soldier				Army		Baltimore County, Md.			USA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Benjamin C. Howard						Katherine Browne					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT			Address		
Yes				1942 - 1959		218-10-0348			Wife (same as above)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										INTERVAL BETWEEN ONSET AND DEATH	
Left intracerebral Hemorrhage											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO											
DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19											
21. I certify that XX (this hospital) attended the deceased from 6 April, 1967, to 9 April, 1967, that XX (we) last saw the deceased alive on 9 April, 1967, and that death occurred at 3:30 PM, from the causes and on the date stated above.											
22a. SIGNATURE						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			22b. DATE SIGNED		
HAROLD C. SHEAFFER, MAJ, MC						Kirk Army Hospital, Aberdeen PG, Md.			9 April 1967		
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
Burial 12 April 1967				Arlington				Arlington, Va			
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
101 Archer						Benson, Md			DATE APR 13 1967 J. Santos Judge		

222

05206

CERTIFICATE OF DEATH

05204

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Chester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE de GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural - Nottingham</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		d. STREET ADDRESS <u>R. 19.2.</u>	
3. NAME OF DECEASED (Type or print) <u>Maryle E Jones</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 22 1891</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Nottingham Imp. Pa</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>W. Nottingham Imp. Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Trason</u>		14. MOTHER'S MARDEN NAME <u>Mary Alice Ferguson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>216-05-8933</u>	
17. INFORMANT <u>Lewis F. Jones - Nottingham R.D. 2. Pa</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Coronary heart failure</u> DUE TO (c) <u>a.s.c.v.d</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>4-1</u>	20f. (City or town) (County) (State) <u>4-8 69</u>
21. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> , 19 <u>67</u> , to <u>4-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Apr. 10</u> , 19 <u>67</u> , and that death occurred at <u>4:15</u> M., from causes on and on the date stated above			
22a. SIGNATURE <u>John D. Y...</u>		22b. DATE SIGNED <u>4/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. Y...</u>		22d. ADDRESS <u>Havre de Grace, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Apr. 14 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nottingham Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Nottingham, Chester Pa</u>
24. FUNERAL DIRECTOR <u>RALPH M. REED RISING SUN, M.D.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 12 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05207				CERTIFICATE OF DEATH				05205			
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MASS.</u> b. COUNTY <u>PITTSFIELD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PITTSFIELD</u> d. STREET ADDRESS <u>95 DANIELS AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>F.</u> Last <u>KELLEEN</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>29</u> Year <u>1967</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-12-1906</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Club Steward</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>				11. BIRTHPLACE (County & State, or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Kelleen</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>314-15 3973</u>		17. INFORMANT <u>Engrica Kelleen, Pittsfield, Mass.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Vascular Disease</u> (c) <u>hypertensive inter cerebral hemorrhage</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>April 29</u> , 19 <u>67</u> , to <u>April 29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 29</u> , 19 <u>67</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward J. Simon</u>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>EDWARD J. SIMON</u>				22d. ADDRESS <u>Home 22 Grace, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>5-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harpur Chapel</u>		23d. LOCATION (City, town or county) (State) <u>Pittsfield, Mass. MA</u>			
24. FUNERAL DIRECTOR <u>Lawrence J. Thomas, Englewood, Md</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
				DATE <u>MAY 3</u> 19 <u>67</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05208

CERTIFICATE OF DEATH

05206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		d. STREET ADDRESS <u>Bayou Villa, Apt 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM SCARFF Kelly</u>		4. DATE OF DEATH Month Day Year <u>APRIL 3 1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JAN. 24, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cooking & Garden Work, Calif.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u>
13. FATHER'S NAME <u>EDGAR C. KELLY</u>		14. MOTHER'S MAIDEN NAME <u>JEANNETTE SCARFF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>550-07-6749</u>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 5th, 1966</u> to <u>APRIL 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>APRIL 3, 1967</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loc, M.D.</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loc, M.D.</u>		22d. ADDRESS <u>Haver de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>APR. 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>HAVER DE GRACE, MD.</u>
24 FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		25a. RECEIVED BY REGISTRAR <u>APR 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

05203

Reg. Dist. No. 05207

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>DEL AIR (RURAL)</u>		c. LENGTH OF STAY IN 1b <u>8 mos</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARF. CONVAL. HOME</u>		e. STREET ADDRESS <u>KNOPP Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>LUELLA</u> Last <u>KNOPP</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 13, 1880</u>	
9. AGE (In years last b. day) <u>87 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		12. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
13. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>HENRY J. HORN</u>		16. MOTHER'S MAIDEN NAME <u>ANNIE C. OBITS</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO <u>220-24-5557</u>	
19. INFORMANT <u>AARON KNOPP</u>		20. ADDRESS <u>OLD FEDERAL HILL ROAD ROCKS, MD 21141</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) _____</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>1YR OVER 10 YRS</u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS, PHYSIOLOGIC FRACTURE RT HIP</u></p>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>RT HIP TURNING IN BED DURING NIGHT</u>	
20c. TIME OF INJURY Month, Day, Year <u>NIGHT FEB 28 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME, HARF. CONVAL.</u>		20f. (City or town) <u>DEL AIR, HARFORD, MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		DATE SIGNED <u>APRIL 1, 1967</u>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>DEL AIR, MD.</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/4/1967</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WILLIAM WATTERS</u>		22d. LOCATION (City, town, or county) <u>COOPTOWN MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES E. KURTZ</u>		24a. REC'D BY REGISTRAR <u>APR 4 1967</u>	
ADDRESS <u>JARRETTVILLE, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kurtz</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05210

05208

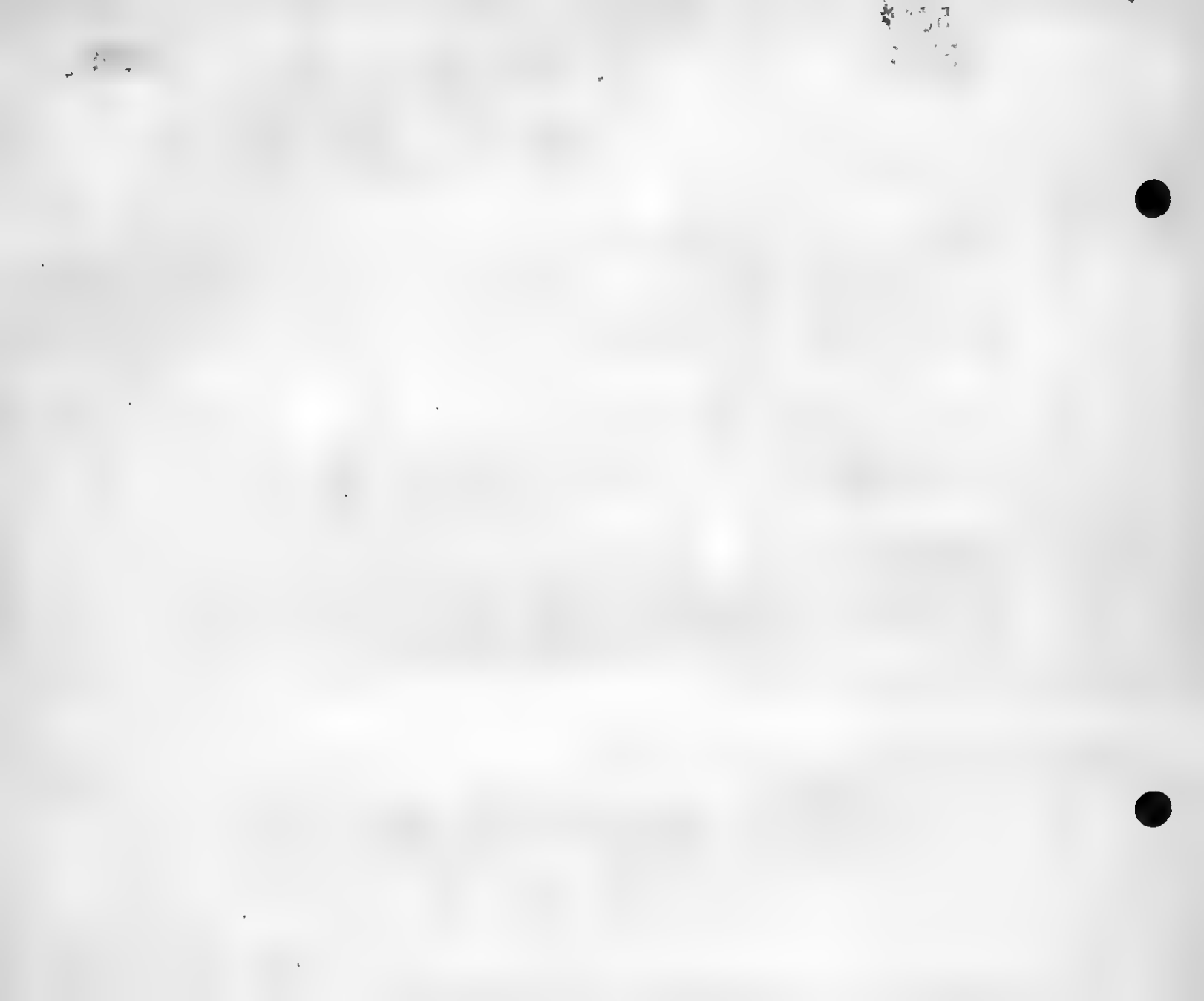
1 PLACE OF DEATH a COUNTY Harford MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Harford			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital - DOA				d STREET ADDRESS 2304 Willoughby Beach Road			
3 NAME OF DECEASED (Type or print) First BLANCHE Middle LILLIAN Last LANTZ				4 DATE OF DEATH Month APRIL Day 23 Year 1967			
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Oct. 6, 1890	
9 AGE (in years) 76 yrs		10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY home		11 BIRTHPLACE (State or foreign country) Bradshaw, Maryland	
12 CITIZENSHIP OF WHAT COUNTRY? USA				13 FATHER'S NAME Leonard Knight			
14 MOTHER'S MAIDEN NAME Angeline Ocelia Greenland				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16 SOC. SEC. NO. 213-36-8900				17 INFORMANT Helen B. Lantz, 2304 Willoughby Beach Road			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic C V Disease Heart DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gerald C Palmer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED April 24, 1967				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE THEREOF April 26, 1967		23c NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery	
23d LOCATION (City or Town) Joppa				23e (County) Harford		23f (State) Md	
24 FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009				25a REC'D BY REGISTRAR APR 26 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05211				CERTIFICATE OF DEATH				05209			
Item #14 infor. taken from birth cert.											
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Bruce</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>					
c. LENGTH OF STAY IN 1b <u>36 hr.</u>						d. STREET ADDRESS <u>Box 94</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Baby Girl "B"</u> First Middle Last <u>Lawson</u>						4. DATE OF DEATH <u>APRIL 27</u> 19 <u>67</u> Month / Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-25-67</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>12</u> Hours <u>12</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Larry Randolph Lawson</u>						14. MOTHER'S MAIDEN NAME <u>Mary Estella Hampton</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT (Print) <u>Mr. Larry R. Lawson</u> Address <u>Box #94 Churchville Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> 7-35 DUE TO (b) <u>Respiratory Distress Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) <u>Hyaline Membrane Disease</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PREMATURITY</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 25</u> , 19 <u>67</u> , to <u>April 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 27</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Alonso Gomez</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/27/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Alonso Gomez</u>						22d. ADDRESS <u>419 S. Union Ave - Wakefield</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air Harford Co., Maryland 21014</u>					
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St Bel Air Maryland 21014</u>						25a. REC'D BY REGISTRAR <u>MAY 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05212

05210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURDE GRACE</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				e. STREET ADDRESS <u>Darlington</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>WILSON</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 7, 1883</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUCTIONEER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ADDISON W. LEE</u>				14. MOTHER'S MAIDEN NAME <u>ELLA P. McCANN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-1796</u>		17. INFORMANT Address <u>MRS. H.F. ANTHONY, JR., DARLINGTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS AND Unregulate HT</u> DUE TO (c) <u>failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>67</u> , to <u>APRIL 15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>APRIL 15</u> , 19 <u>67</u> , and that death occurred at <u>11</u> ⁴³ P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Dudley Phillips</u>				22b. DATE SIGNED <u>4/16/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>	
22d. ADDRESS <u>DARLINGTON, MD.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APR. 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>		23d. LOCATION (City, town or county) (State) <u>DARLINGTON, MD.</u>	
24. FUNERAL DIRECTOR <u>John H. Harkin, DELTA PA.</u>				25a. REC'D BY REGISTRAR <u>APR 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05213

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05211

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Ohio b. COUNTY Coshocton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		c. LENGTH OF STAY IN 1b Coshocton	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Kirk Army Hospital 204		d. STREET ADDRESS Route #4	
3 NAME OF DECEASED (Type or print) First Middle Last Stanley Lewis		4 DATE OF DEATH Month Day Year April 15 1967	
5 SEX Male	6 COLOR OR RACE Caucasian	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 14 June 1915
9 AGE (In years last birthday) yrs 51		10. F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General Labor	
11 BIRTHPLACE (State or foreign country) Ohio		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME John Lewis		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-II		16 SOCIAL SECURITY NO. 274-12-2158	
17 INFORMANT Dawson Funeral Home, Ohio		Address Coshocton,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C. Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 4-15-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Bel Air, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE THEREOF 16 April 67		23c. NAME OF CEMETERY OR CREMATORY Prairie Chapel Cemetery, Coshocton Ohio	
23d. LOCATION (City or Town) (County) (State) Coshocton Ohio		24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md.	
25a. REC'D BY REGISTRAR April 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05214					05212				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)				
a. COUNTY Harford					a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					b. COUNTY Harford				
Aberdeen Proving Ground					Abingdon				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
4 Days					13-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
Kirk Army Hospital					4228 Birch Avenue				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
Charles LEONARD LINDSEY Jr.					April 24 1967				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		21 April 1967		4 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
						Harford, Maryland		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Charles L. Lindsey					Murphy Patricia Murphy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				Father		(Same as above)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a). Prematurity - hyaline membrane pulmonary disease									
7735 DUE TO (b) physiologic jaundice									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (this hospital) attended the deceased from 21 April , 19 67 , to 24 April , 19 67 , that (we) last saw the deceased alive on 24 April , 19 67 , and that death occurred at 440 PM , from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		
Leland Wight					25 April 1967		LELAND WIGHT, CPT, MC		
22d. ADDRESS					22e. ADDRESS				
Kirk Army Hospital, APG, Md.					Kirk Army Hospital, APG, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		April 27, 1967		Bel Air Memorial Gardens		Bel Air Harford Co. Maryland 21014			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Joseph William Foster					APR 27 1967		Charles Judge		



05215

CERTIFICATE OF DEATH

05213

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before adm. ssion) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		d. STREET ADDRESS <u>Rd 3</u>	
3. NAME OF DECEASED (Type or print) <u>Emil</u> First Middle Last <u>Macko</u>		4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Sept. 1906</u>
9. AGE (In years last birthday) yrs. <u>60</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Karl Mackovi</u>		14. MOTHER'S MAIDEN NAME <u>Cecilie Kundraby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO <u>217-14-3768</u>	
17. INFORMANT <u>Alphonse J. Hostinek, Baltimore Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> (c) <u>A.S.C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>?</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4/30/1</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital), attended the deceased from <u>Jan. 20</u> , 19 <u>61</u> , to <u>April 6th</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 6th</u> , 19 <u>67</u> , and that death occurred at <u>2:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>4/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harford</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8 April 67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Perryman (Harford) Md.</u>	
24. FUNERAL DIRECTOR <u>Helena Macomber Sr.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 10 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05216

05214

1 PLACE OF DEATH a COUNTY Harford MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Harford				
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Edgewood			c LENGTH OF STAY IN 1b 16 years		c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Edgewood			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) --				d STREET ADDRESS 335 McCann Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First VIRGIN Middle EDITH Last McDANIEL				4 DATE OF DEATH Month April Day 12 Year 19 67				
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Feb. 16, 1899		
9 AGE (In years last birthday) yrs 68		F UNDER 1 YEAR Months 12 Days 19 Hours 67		F UNDER 24 HRS Hours Min				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b KIND OF BUSINESS OR INDUSTRY --		11 BIRTHPLACE (State or foreign country) Kentucky		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William E. Hunter				14 MOTHER'S MAIDEN NAME Elizabeth Thompson				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO none		17 INFORMANT Mrs. Jewell B. Dudley, 335 McCann St. Edgewood		Address Md		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic C V disease 260X DUE TO (b) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Gerald C. Palmer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md.				
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md.				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Bel Air, Md.				Address (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF April 15, 1967		23c NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d LOCATION (City or Town) (County) (State) Bel Air Harford Md		
24 FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				25a REC'D BY REGISTRAR APR 14 1967		25b REGISTRAR'S SIGNATURE Charles Judge		

12



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05217

CERTIFICATE OF DEATH

05215

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u>			
c. LENGTH OF STAY IN 1b <u>59 DAYS</u>				d. STREET ADDRESS <u>200 Fitzhugh Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>LUCILLE</u> Last <u>McHENRY</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>22</u> Year <u>1967</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 28-1899</u>		9. AGE (In years last birthday) <u>68</u> yrs.		10. FUND 1 YEAR <input type="checkbox"/> FUND 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Wks</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Boyd Co. Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Howell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Connelly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>261-10-0378</u>		17. INFORMANT <u>Mrs. Woodward Bartlett</u> Address <u>200 Fitzhugh Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, extensive</u> 4/20/1 DUE TO (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease 2 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Hypothyroidism, Fatty Degeneration of Liver</u>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Feb 23, 1967</u> , to <u>April 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 22, 1967</u> , and that death occurred at <u>5:30 M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>				22b. DATE SIGNED <u>4/22/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				22d. ADDRESS <u>HAVER DE GRACE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bonsert Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Bonerton Phila. Co. Pa.</u>	
24. FUNERAL DIRECTOR <u>Wm. Haver de Grace, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 25 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05218

CERTIFICATE OF DEATH

05216

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVER de GRACE</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				e. STREET ADDRESS <u>109 Van Diver Ct.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William FRAZIER McMillion</u>				4. DATE OF DEATH Month Day Year <u>April 13 1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/29/1875</u>	
9. AGE (in years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Esty, West Virginia</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>State Road</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank McMillion</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>176-07-8734</u>		17. INFORMANT <u>Mrs. Ann Gregory</u>		109 <u>Van Diver Ct.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u> DUE TO (b) <u>Cerebral arterio-sclerosis</u> DUE TO (c) <u>1 day</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 12, 1967</u> to <u>April 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 13, 1967</u> , and that death occurred at <u>2:35</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Irvin Nachsman</u>				22b. DATE SIGNED <u>4/13/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Irvin Nachsman</u>	
22d. ADDRESS <u>Haver de Grace, Maryland</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/15/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fallston Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Fallston, Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>				25a. REC'D BY REGISTRAR <u>APR 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John L. Jones</u>	

9.1.2

FOR STATE HEALTH DEPT.

05219

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05218

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrodsburg</u>		c. LENGTH OF STAY in 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.A. 1st and Second Memorial Hospital</u>				d. STREET ADDRESS <u>RD 1, Box 80-D</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>Monk</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1939</u>	9. AGE (in years last birthday) <u>27</u> yrs	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Hartford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Estell Monk</u>				14. MOTHER'S MAIDEN NAME <u>Irena May Woods</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>213-36-9902</u>		17. INFORMANT (wife) <u>457-4766</u> <u>Mrs. Peggy Y. Monk</u>		Address <u>RD #1 Box # 80-D</u> <u>Darlington, Maryland 21034</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO (b) <u>Auto Acc</u> DUE TO (c) <u>Skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <u>Auto Acc</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto Acc</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4</u> p.m. <u>22</u> <u>67</u>		20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> Not where <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Conowingo Bridge Rd</u>		20f. (City or town) (County) (State) <u>Darlington</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>				Address (Street, city, town, or county) <u>4-2367</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Hartford Co., Maryland 21014</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St.</u> <u>Bel Air, Maryland 21014</u>				25a. REG'D BY REGISTRAR DATE <u>APR 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

100



35220

CERTIFICATE OF DEATH

05217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>		d. STREET ADDRESS <u>CHapel Road</u>	
3. NAME OF DECEASED (Type or print) <u>Hester EARL Meyers</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 19 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
11. BIRTHPLACE (County & State, or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. G. Meyers</u>		14. MOTHER'S MAIDEN NAME <u>Laura M. Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WAGONER 4TH REGT</u>		16. SOCIAL SECURITY NO <u>174-10-2919</u>	
17. INFORMANT <u>Rebecca A. Meyers</u>		Address <u>RD #3 Box 67</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Disease</u> (b) <u>2-3 yrs.</u> (c) <u>Sudden</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10th, 1967</u> to <u>April 8, 1967</u> that (I) (we) last saw the deceased alive on <u>April 8th, 1967</u> , and that death occurred at <u>2:40 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/8/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Haver de Grace Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HAYS CEM.</u>	23d. LOCATION (City or town) (County) (State) <u>EASTON NORTH PA.</u>
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		ADDRESS <u>Harford Exch. Md.</u>	25a. REC'D BY REGISTRAR <u>APR 13 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
05221 1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fallston c. LENGTH OF STAY IN It 39 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) (U.S. #1) Bel Air Road						05219 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fallston d. STREET ADDRESS (U.S. #1) Bel Air Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Myrtle Middle Florence Last Neikirk				4. DATE OF DEATH Month April Day 25 Year 19 67							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 12, 1889		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (County & State, or foreign country) Harford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob A. Doxen						14. MOTHER'S MAIDEN NAME Elizabeth Beaumont					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-18-7307		17. INFORMANT (Brother) 838-6148 address Mr. William B. Doxen Bel Air, Md. 21014					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic CV Disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-1 , 19 45 , to 4-25 , 19 67 , that (I) (we) last saw the deceased alive on 2-15 , 19 67 , and that death occurred at 9P. M. from the causes and on the date stated above.											
22a. SIGNATURE Gerald C. Palmer						22b. DATE SIGNED April 26, 1967					
22c. PHYSICIAN'S NAME (Type) Gerald C. Palmer, M.D.						22d. ADDRESS S. Main St., Bel Air, Md. 21014					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Apr. 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Meth. Ch. Cem.		23d. LOCATION (City, town or county) (State) Fountain Green, Harf. Co., Md.			
24. FUNERAL DIRECTOR W. Broadway & Williams St. Bel Air, Maryland 21014						25a. REC'D BY REGISTRAR APR 27 1967					
Joseph William Foster						Charles Judge					

Joseph William Foster

1947

1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a discussion of the results of the study.

4. The fourth part of the report is a conclusion and a list of references.

5. The fifth part of the report is a list of appendices.

6. The sixth part of the report is a list of figures and tables.

7. The seventh part of the report is a list of footnotes.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05222

05220

1 PLACE OF DEATH a COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived f institution; Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Harford</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
c LENGTH OF STAY IN 1b <u>3 years</u>		d STREET ADDRESS <u>538 Trimble Road</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dragon Wagon Trailer Co.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Walter M Niehoff</u>		4 DATE OF DEATH <u>April 22 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 6, 1902</u>
9 AGE (In years, birthdate) <u>64</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>	10b KIND OF BUSINESS OR INDUSTRY <u>Steel</u>
11 BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Herman Niehoff</u>		14 MOTHER'S MAIDEN NAME <u>Susan Mercer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>218-14-5600</u>	
17. INFORMANT <u>Wiley T. Richardson, 1627 Riverwood Rd,</u>		Address <u>Baltimore, Md.</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVA. BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>4-22-67</u>	
Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>April 24, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d LOCATION (City or Town) (County) (State) <u>Bel Air Harford Md</u>
24 FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		25a REC'D BY REGISTRAR <u>APR 25 1967</u>	
ADDRESS		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10

10



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05223

CERTIFICATE OF DEATH

05221

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville 12.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #1, Box 466		d. STREET ADDRESS Route #1, Box 466	
3. NAME OF DECEASED (Type or print) First HAROLD Middle A. Last NOBLE JR.		4. DATE OF DEATH Month April Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1916
9. AGE (In years last birthday) yrs. 50		IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min 0	
10a. USUAL OCCUPATION ON (Give kind of work done during most of work ng life, even if retired) Technical Director		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. Aber. Pr. Gd.	
11. BIRTHPLACE (County & State, or foreign country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dev. & Pr. Sves. Harold A. Noble Sr.		14. MOTHER'S MAIDEN NAME Edna Snyder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 511-01-9259	
17. INFORMANT Mrs. Iris Noble, Churchville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Ischemia 4.001 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH One hour One hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atrial fibrillation chronic, Cause undetermined		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-17-1951 to 4-22-1967 that (I) (we) last saw the deceased alive on 4-22-1967 , and that death occurred at 6:15 PM from causes and on the date stated above.			
22a. SIGNATURE Peter P. Rodman		22b. DATE SIGNED 4-22-1967	
22c. PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.		22d. ADDRESS 8 Law Street, Aberdeen, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 26 April 67	
23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens, Aberdeen, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Walter Macomber Jr.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 26 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05224

CERTIFICATE OF DEATH

05222

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAURE DE GRACE</i>		c. LENGTH OF STAY IN 1b <i>DOA</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural- Aberdeen</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>				d. STREET ADDRESS <i>Stephney Rd. Rt #1 Box 88</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>FRANCES</i> Middle <i>R.</i> Last <i>PEEVY</i>				4. DATE OF DEATH Month <i>April</i> Day <i>25</i> Year <i>1967</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 14 1889</i>		9. AGE (In years last birthday) <i>77</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Berryman Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Daniel Webster</i>				14. MOTHER'S MAIDEN NAME <i>Mamie Williams</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>215-28-9016</i>		17. INFORMANT <i>Mr. John C. Peery, Aberdeen, Md.</i> Address <i>Rt. 41 Box 88</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO (b) <i>Essential Hypertension</i> DUE TO (c) <i>1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <i>15 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4-25-67</i> to <i>4-25-67</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4-25-67</i> 19 <i>67</i> , and that death occurred at <i>10:00</i> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Paul P. Rogers, M.D.</i>				22b. DATE SIGNED <i>4-25-67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Paul P. Rogers, M.D.</i>				22d. ADDRESS <i>Aberdeen, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>April 29, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Aberdeen, Harford Co. Md.</i>	
24. FUNERAL DIRECTOR <i>Otelia J. Bullock, Hare de Grace, Md.</i>				25. REGISTERED BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05225 CERTIFICATE OF DEATH 05223											
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>					
c. LENGTH OF STAY IN 1b <u>11 hrs.</u>						d. STREET ADDRESS <u>661 OTsego ST</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARford Memorial Hosp.</u>											
3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>Poncez</u> Last <u>Poncez</u>						4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/23/1912</u>		9. AGE (in years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Works</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Broughton Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Poncez</u>						14. MOTHER'S MAIDEN NAME <u>Katherine Pukay</u> (3814 Dupont Ave. N.Y. 10469)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>232-26-9131</u>		17. INFORMANT <u>Mrs. Della Newman</u> (Address)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> <u>Pneumonia.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that (I) (this hospital) attended the deceased from <u>April 9, 1967</u> to <u>April 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 10, 1967</u> , and that death occurred at <u>9:04</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						22b. DATE SIGNED _____					
22c. PHYSICIAN'S NAME (Type) _____						22d. ADDRESS _____					
23a. BURIAL, CREMATION, REMOVAL (Specify) _____			23b. DATE THEREOF <u>4/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>			23d. LOCATION (City, town or county) _____ (State) _____			
24. FUNERAL DIRECTOR <u>Cunningham Hare & Son, Inc.</u> ADDRESS _____						25a. REC'D BY REGISTRAR <u>APR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

05226

Item #8 Film #G387 4/17/67

CERTIFICATE OF DEATH

05224

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>1143 Bushkill St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>WILLIAM</u> Last <u>POTOMIS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 6, 1896</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>19</u>		IF UNDER 24 MRS. Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Belt-STEEL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN POTOMIS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET GETCHONIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WORLD WAR #1</u>		16. SOCIAL SECURITY NO <u>174-10-9356</u>		17. INFORMANT <u>Mrs. Sallie R. Potomis</u> <u>1143 Bushkill St. Easton, Pa.</u>			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia & Cardiac decompensation</u> DUE TO (b) <u>Carcinoma of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>163X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <u>4-7</u> , 19 <u>67</u> , to <u>4-9</u> , 19 <u>67</u> that (1) (we) last saw the deceased alive on <u>4-9</u> , 19 <u>67</u> , and that death occurred at <u>7:35 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>AW. GRIGOLEIT</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>AW. GRIGOLEIT</u>				22d. ADDRESS <u>Haure de Grace</u>			
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY SAVIOR CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BETHLEHEM, North. PA.</u>	
24. FUNERAL DIRECTOR <u>R. Madison Mitchell, Haure de Grace, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

05227

CERTIFICATE OF DEATH

05225

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. LENGTH OF STAY in 1b <u>23 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial</u>		d. STREET ADDRESS <u>201 Bay 87</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Cloud Pyle</u>		4. DATE OF DEATH <u>4</u> <u>19</u> <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 13, 1889</u> <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of Seal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State or foreign country) <u>PA. Penna</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Carleton J. Pyle</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mercer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>190-16-9236</u>	
17. INFORMANT <u>DEAN RICHARDS PYLE</u> Address <u>FALLSTON MD 20487</u>		18. CAUSE OF DEATH (Enter only one cause per line (or (d), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>A.S. C.V.D., Class IV, D.</u> Conditions, if any, which gave rise to immediate cause (b) <u>—</u> DUE TO <u>—</u> Listing the underlying cause last. (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>Prostatic hypertrophy and urinary retention</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year <u>3/12</u> <u>1967</u> Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg; etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> , 19 <u>67</u> to <u>April 4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>April 4</u> , 19 <u>67</u> and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loomis</u> M.D.		22b. DATE SIGNED <u>4/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loomis</u>		22d. ADDRESS <u>Hayre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>APRIL 8, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MD.</u>	
24. FUNERAL DIRECTOR <u>R. Madson Mitchell</u>		25a. RECD BY REGISTRAR <u>APR 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		25c. ADDRESS <u>—</u>	

05228

CERTIFICATE OF DEATH

05226

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		d. STREET ADDRESS <u>Conowingo, Md.</u>	
3 NAME OF DECEASED (Type or print) <u>Baby Boy Ratliff</u>		4 DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9 AGE (In years last birthday) yrs. <u>16</u> Min. <u>11</u>
11 BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Marvin Ratliff</u>		14. MOTHER'S MAIDEN NAME <u>Betty Streed</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>none</u>	
17 INFORMANT <u>Marvin Ratliff - Conowingo Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>7543</u> DUE TO <u>Congenital Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Enteric and Septic System</u> (c) <u>Septicemia</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/2, 1967</u> to <u>4/3, 1967</u> , that (I) (we) last saw the deceased alive on <u>4/3, 1967</u> , and that death occurred at <u>5:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Hatten</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>4/6/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>	23d LOCATION (City or town) (County) (State) <u>Rome Va.</u>
24 FUNERAL DIRECTOR <u>Lawrence R. Hand</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>	
ADDRESS <u>Harford, Md.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05229					05227						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <u>Harford</u>					a. STATE <u>Maryland</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>					b. COUNTY <u>Harford</u>						
c. LENGTH OF STAY IN 1b <u>2 yrs.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Convalescing Home</u>					d. STREET ADDRESS <u>Jarrettsville Road</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED			First		Middle		Last		4. DATE OF DEATH		
(Type or print)			<u>Roberta</u>		<u>R.</u>		<u>Reynolds</u>		Month <u>April</u> Day <u>11</u> Year <u>19 67</u>		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
<u>Female</u>	<u>White</u>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>4/10/1868</u>	<u>99</u> yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Stafford, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Emm or Rees</u>					14. MOTHER'S MAIDEN NAME <u>Priscilla Ross</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-52-2203</u>		17. INFORMANT <u>Mrs. Priscilla Stansbury</u>			Address <u>112 J. University Parkway Balto. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen. Arteriosclerosis</u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 20</u> , 19 <u>47</u> , to <u>Apr. 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 30</u> , 19 <u>67</u> , and that death occurred at <u>1 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert Barthel</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Apr. 11/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Robert Barthel M.D.</u>					22d. ADDRESS <u>Forest Hill, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
<u>Burial</u>			<u>4/13/1967</u>		<u>William Watters</u>			<u>Coontown, Maryland</u>			
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>					ADDRESS <u>Jarrettsville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

05230

CERTIFICATE OF DEATH

05228

1 PLACE OF DEATH a. COUNTY Hafford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #3,		d. STREET ADDRESS Route #3, Box 69	
3 NAME OF DECEASED (Type or print) First ALICE Middle W. Last RICHARDSON		4 DATE OF DEATH Month April Day 4 Year 1967	
5 SEX Female	6 COLOR OR RACE Caucasian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 26 July 1893
9 AGE (In years last birthday) 73 yrs		10 IF UNDER 1 YEAR Months 4 Days 19 Hours 67 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Wright		14. MOTHER'S MAIDEN NAME Emma Elizabeth James	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 220-46-1087	
17 INFORMANT G. Willard Richardson, Aberdeen, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) DUE TO (c) Arteriosclerotic heart and lung disease		INTERVAL BETWEEN ONSET AND DEATH over 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 9:30 p.m. from causes and on the date stated above.			
22a. SIGNATURE L. Mezei		22b. DATE SIGNED 4/5/67	
22c. PHYSICIAN'S NAME (Type) L. Mezei, M.D.		22d. ADDRESS Havre de Grace, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 7 April 67	23c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery	23d LOCATION (City or Town) (County) (State) Perryman (Harford) Md.
24. FUNERAL DIRECTOR Walter Macomber Jr.		25a REC'D BY REGISTRAR APR 7 1967	
ADDRESS Tarring Funeral Home, Aberdeen, Md.		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05231

CERTIFICATE OF DEATH

05229

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVERDEGRACE</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Benson</u>			
c. LENGTH OF STAY IN 1b <u>4 days</u>				d. STREET ADDRESS <u>703 Whitaker Mill Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>SHANAHAN</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>29</u> Year <u>1967</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4 1905</u>		9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Care Taker C.F.A.C. Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md. Balto.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>md. Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Shanahan</u>				14. MOTHER'S MAIDEN NAME <u>Louise Kearney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>015-01-2332</u>		17. INFORMANT <u>Kathryn L. Shanahan 703 Whitaker Mill Rd</u> Address <u>703 Whitaker Mill Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma head of Pancreas with</u> <u>157X</u> DUE TO (b) <u>obstructive and metastatic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>bilateral adrenal metastases</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> , 19 <u>67</u> , to <u>APRIL 29 1967</u> that (I) (we) last saw the deceased alive on <u>APRIL 29 1967</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loomis</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loomis, MD</u>				22d. ADDRESS <u>Haverdegrace, Ind</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Com.</u>		23d. LOCATION (City, town or county) (State) <u>Long Green Md.</u>	
24. FUNERAL DIRECTOR <u>Riegel Bros Inc</u>				ADDRESS <u>7110 Baker Rd</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 3 1967</u>							

FOR STATE
HEALTH DEPT.

05232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05230

1 PLACE OF DEATH a COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Harford	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Harre de Grace		c LENGTH OF STAY IN 1b Edgewood	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital - DOA		d STREET ADDRESS 3917 Love Drive	
3. NAME OF DECEASED (Type or print) First FRED Middle LEONARD Last SHEETS		4 DATE OF DEATH Month APRIL Day 26 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 23, 1929
9 AGE (n years last birthday) yrs 37		10 IF UNDER 1 YEAR Months Days Hours Min 26	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b KIND OF BUSINESS OR INDUSTRY auto	
11 BIRTHPLACE (State or foreign country) Bakersville, N.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Isaac Sheets		14 MOTHER'S MAIDEN NAME Rose Fyre	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 409-460428	
17 INFORMANT Mrs. Evelyn Sheets, 5 W. Midland Ave.,		Address Balto., Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured Skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Auto Accident	
20c TIME OF INJURY Month, Day, Year Hour a.m. 4:50 p.m. 4-26-1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 3	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Willoughby Beach Rd Edgewood Har Md.		20f. (City or town) (County) (State) Edgewood Har Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald E Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bo-Air m.	
EXAMINER'S NAME (Type) Gerald E Palmer - M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-26-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Removal		23b DATE THEREOF Apr 26, 1967	
23c NAME OF CEMETERY OR CREMATORY Henline Funeral Home		23d LOCATION (City or Town) (County) (State) Bakersville Mitchell Co., N.C.	
24 FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		25a REC'D BY REGISTRAR MAY 1 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05233

CERTIFICATE OF DEATH

05231

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>			
c. LENGTH OF STAY IN 1b <u>23 days</u>				d. STREET ADDRESS <u>Rd # 1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lyman Jones Smith</u>				4. DATE OF DEATH Month Day Year <u>4 22 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20, 1981</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward B. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Gunthrie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-36-0014</u>		17. INFORMANT Address <u>R.D. #1 North East, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senility</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> , 19 <u>67</u> to <u>4-22</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4/22/67</u> and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>				22b. DATE SIGNED <u>4/22/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bay View Meth</u>	
23d. LOCATION (City, town or county) (State) <u>Cecil Co. Md.</u>				23e. RECORD BY REGISTRAR <u>APR 26 1967</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR <u>Grant Funeral Home</u>				24a. ADDRESS <u>Box 26 North East, Md.</u>		24b. REGISTRAR'S SIGNATURE	

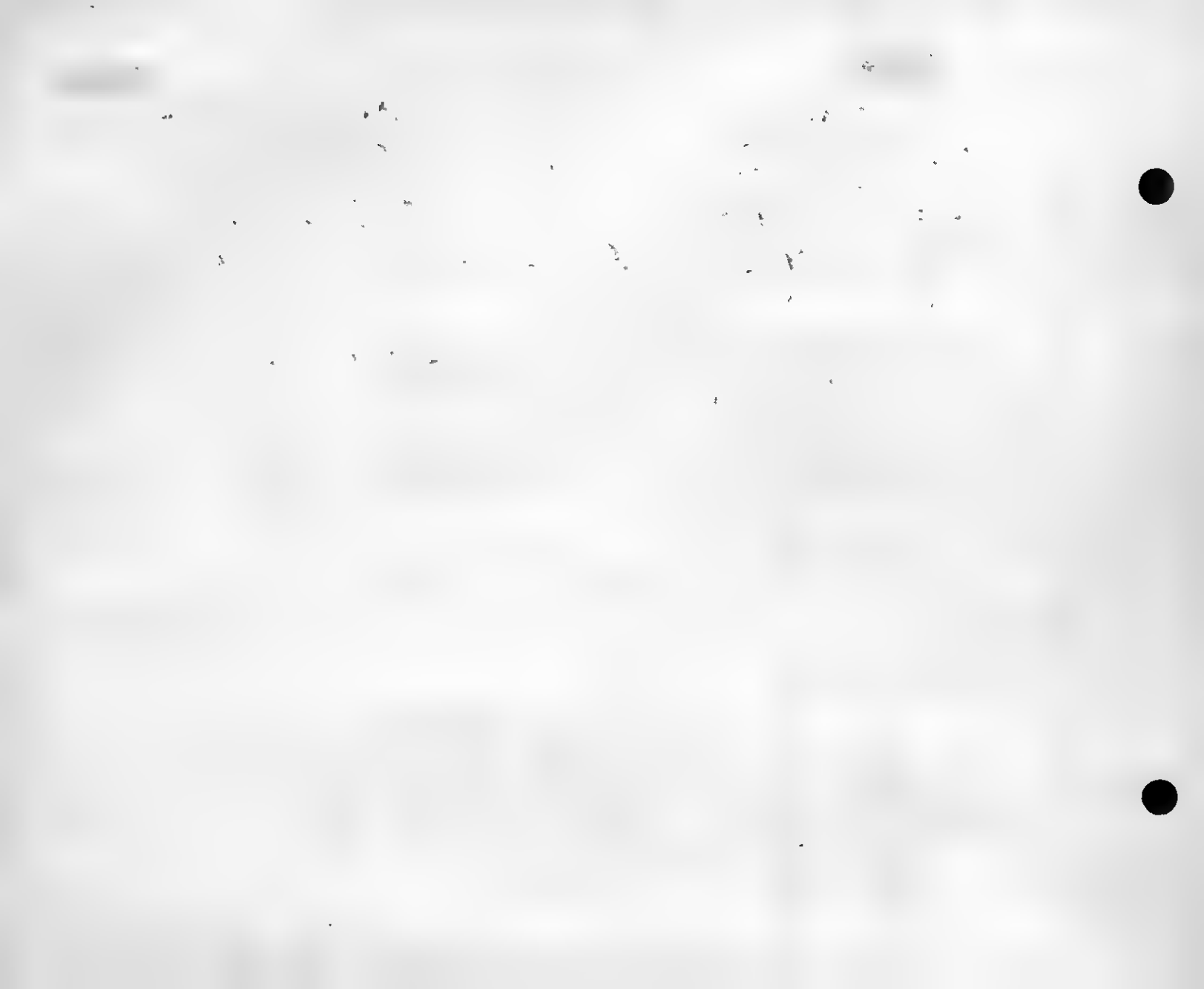
CERTIFICATE OF DEATH

05222

MEDICAL CERTIFICATION

VR A15 (4)
20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05235

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05233

1 PLACE OF DEATH a COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) f Institution Residence before admission a STATE <u>MD</u> b COUNTY <u>Frederick</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2271 W. 17th</u>		c LENGTH OF STAY IN lb <u>MT. AIRY</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Susquehanna River</u>		d STREET ADDRESS <u>109 Prospect Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Robert Francis Thomas, Jr.</u>		4 DATE OF DEATH <u>April 14</u> 19 <u>67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 10, 1942</u>
9 AGE (in years last birthday) <u>24</u> yrs		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, County, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Robert F. Thomas, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Edith Haines</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>218-40-0863</u>	
17. INFORMANT <u>Martha L. Thomas, Item 2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia due to Drowning</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I or term 18) <u>Fell out of Boat</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>3-31</u> 19 <u>67</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Susquehanna River</u>	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P. Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/Hill, MD</u>	
EXAMINER'S NAME (Type) <u>Gerald P. Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22 DATE SIGNED <u>4-14-67</u>	
Address (Street city town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>4/16/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>	23d LOCATION (City or town) (County) (State) <u>Mt. Airy, Md.</u>
24 FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>		25a REC'D BY REGISTRAR DATE <u>APR 17 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

100

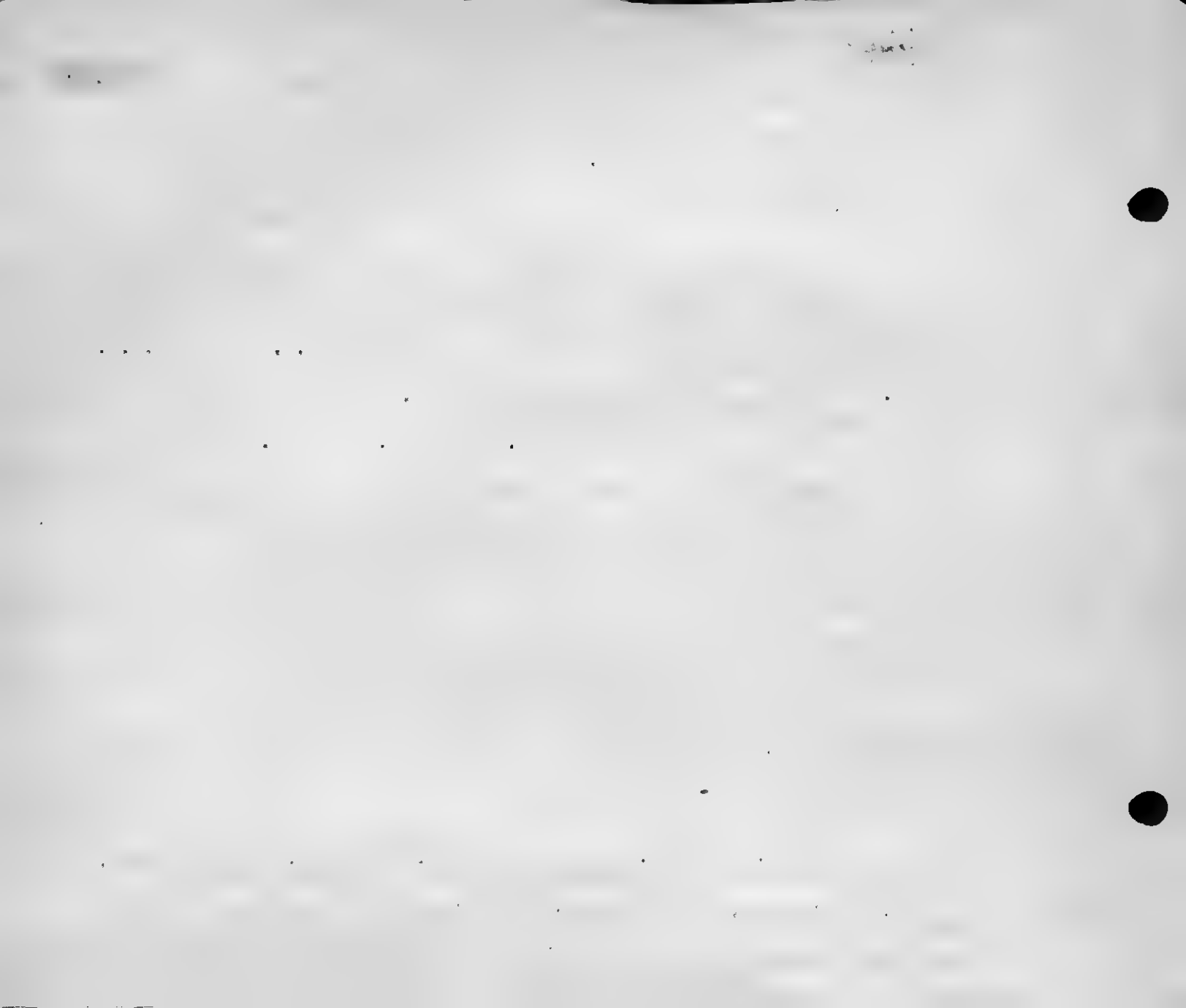
05236

CERTIFICATE OF DEATH

05234

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace c. LENGTH OF STAY IN b. Unk. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Citizens Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air d. STREET ADDRESS 614 Shamrock Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles First Sthaley Middle Thorn Last	4. DATE OF DEATH April 17, Month 19 67 Year	5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 23, 1886	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 4 Days 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Same	11. BIRTHPLACE (County & State, or foreign country) Bordentown, N.J.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David C. Thorn	14. MOTHER'S MAIDEN NAME Ida Z. Elliott	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Address Mr. Charles S. Thorn Jr. Bel Air, Md	
18. CAUSE OF DEATH [Enter only one cause per item for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (b) Adenocarcinoma of Colon (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 2 months 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from March 14th 1967 to April 17th 1967 that (I) (we) last saw the deceased alive on April 17th 1967 and that death occurred at 1:20 PM from the causes and on the date stated above. 22a. SIGNATURE Edward C. Loo, M.D. 22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.			22b. DATE SIGNED 4/17/67 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 211 N. Union Ave. Havre de Grace, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF April 20, 1967	23c. NAME OF CEMETERY OR CREMATORY Bordentown Cemetery	23d. LOCATION (City, town or county) (State) Bordentown, New Jersey
24. FUNERAL DIRECTOR'S SIGNATURE Pennington + Son Havre de Grace, Md		25a. REC'D BY REGISTRAR APR 20 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT. M

05237

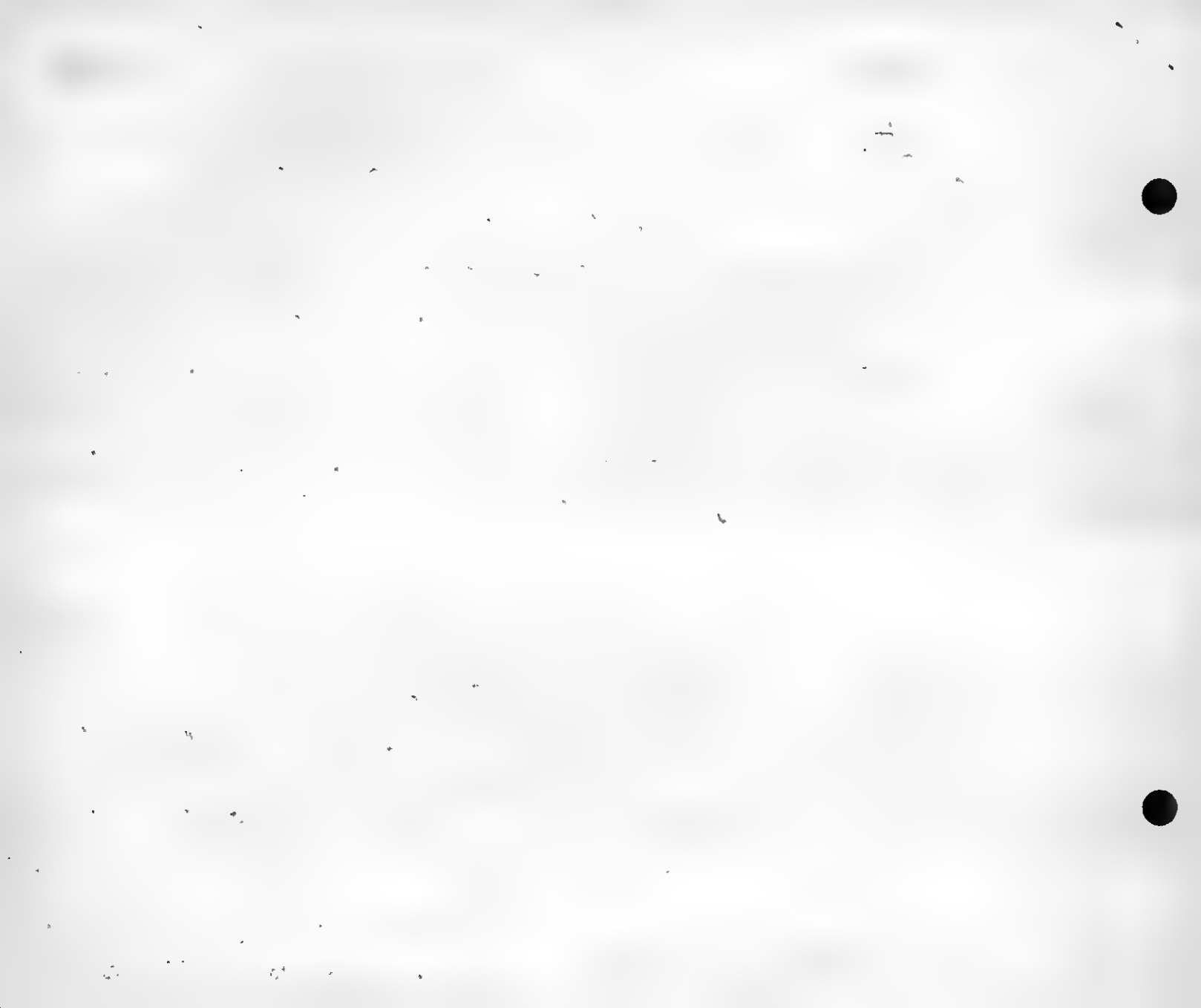
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05235

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		d. STREET ADDRESS <u>Route #1, Box 247</u>	
3 NAME OF DECEASED (Type or print) <u>Edward Turnbaugh</u>		4. DATE OF DEATH <u>April 6 1967</u>	
5 SEX <u>M</u>	6. CO. DR. DR. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 Feb. 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore County Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William Turnbaugh</u>		14 MOTHER'S MAIDEN NAME <u>Mary Ann Cockran</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>217-07-6644-A</u>	
17. INFORMANT <u>Clarence D. Turnbaugh,</u>		Address <u>Churchville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO <u>9123</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Multiple injuries</u> DUE TO (b) <u>Multiple injuries</u> DUE TO (c) <u>Multiple injuries</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Tractor rolled on him</u>	
20c. TIME OF INJURY Month Day, Year <u>11:35 PM 4-6-67</u>		20d. NATURE OF INJURY <u>Service Sta. Havre de Grace</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Service Sta. Havre de Grace</u>		20f. (City or town) <u>Hartford</u> (County) <u>Md.</u> (State) <u>Md.</u>	
21 I certify that I took charge of the remains described above. I held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/Air, ml.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>4-6-67</u>	
Address (Street, city, town or county)			
23a. BURIAL CREMATION, REMOVAL, SPECIAL	23b. DATE THEREOF <u>9 April 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jarrettsville Cemetery, Jarrettsville, Md.</u>	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR <u>Walter McCaskey Jr.</u>	Tarringtons Funeral Home		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
REC'D BY REGISTRAR		DATE <u>APR 10 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05238

CERTIFICATE OF DEATH

05236

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRE-DE-GRACE</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Henry Unglaub</u>		4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1874</u>
9. AGE (In years, last birthday) <u>93 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>29</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R.R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Miller Unglaub</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Haug</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>17-07-6971</u>	
17. INFORMANT <u>Doris J. Stemler, dght. above</u>		Address <u>above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Transitional Ca of left kidney & bilateral</u> DUE TO (c) <u>acute & chronic pyelonephritis & hematuria</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>4-24</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-24, 1967</u> to <u>4-29, 1967</u> , that (I) (we) last saw the deceased alive on <u>4/29/67</u> 19 <u>67</u> , and that death occurred at <u>4:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Grigoleit MD</u>		22b. DATE SIGNED <u>4/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALF GRIGOLEIT</u>		22d. ADDRESS <u>HARRE-DE-GRACE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Schimmek Funeral Home</u> <u>3331 Brehms Lane #13</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

05233

CERTIFICATE OF DEATH

05237

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>		e. STREET ADDRESS <u>666 GREEN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Vantor</u> Last		4. DATE OF DEATH <u>April</u> Month <u>9</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/10/1892</u>
9. AGE (in years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant Owner</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicholas Vantor</u>		14. MOTHER'S MAIDEN NAME <u>Hathlem</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>unk.</u>	
17. INFORMANT <u>Nathlem Vantor</u> Address <u>666 Green St. Apt. 3</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Standstill</u> 4330 DUE TO <u>Chronic Cardiac Decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.C.V.D.</u> (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus, bilateral pleural effusion</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u> </u> Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/3/67</u> to <u>4/9/67</u> , that (I) (we) last saw the deceased alive on <u>4/9/67</u> , and that death occurred at <u>6:18 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo</u> M.D.		22b. DATE SIGNED <u>4/9/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Haver de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>4/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	23d. LOCATION (City or town) (County) (State) <u>Haver de Grace, Md.</u>
24. FUNERAL DIRECTOR <u>Funerary Soc. Haver de Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 19 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 12 AND

05240

CERTIFICATE OF DEATH

05238

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>Rt 1; Box 107</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Veeder</u> Last <u>Veeder</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 29, 1889</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Const. & Bldg.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>XXXXX New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-07-8168</u>		17. INFORMANT Address <u>Frances E. Veeder, Aberdeen, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ruptured aortic aneurysm</u> DUE TO (b) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 22, 1967</u> to <u>April 22, 1967</u> that (I) (we) last saw the deceased alive on <u>APRIL 22, 1967</u> and that death occurred at <u>4:45 M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard J. Colfer</u>				22b. DATE SIGNED <u>4/24/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard J. Colfer, M.D.</u>	
22d. ADDRESS <u>Havre de Grace, Maryland</u>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>25 April 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens, Bel Air, Maryland</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>John G. Tarring</u>				25a. REC'D BY REGISTRAR <u>APR 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

05241

05239

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa c. LENGTH OF STAY IN 1b 25 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa d. STREET ADDRESS 2302 Mountain Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First LOUIS Middle MILTON Last WAGONER		4. DATE OF DEATH Month April Day 17 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1918 9. AGE (In years last birthday) 48 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Transfer	11 BIRTHPLACE (County & State, or foreign country) Harford County, Maryland
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Mahlon C. Wagoner, Sr.	
14 MOTHER'S MAIDEN NAME Zollie M. Wilson		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO. 219-07-9749		17. INFORMANT Mahlon C. Wagoner, Jr., 2302 Mountain Road, Address Joppa, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) For Advanced Pulmonary Tuberculosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 9 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6-1 , 19 66 , to 4-17 , 19 67 , that (I) (we) last saw the deceased alive on 4-17 , 19 67 , and that death occurred at 4 p M, from causes and on the date stated above.	
22a. SIGNATURE Fred O. Hodous		22b. DATE SIGNED 4-18-67	
22c. PHYSICIAN'S NAME (Type) Fred O. Hodous, M.D.		22d. ADDRESS Edgewood, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 20, 1967	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City or Town) (County) (State) Bel Air R.D. Harford Md
24 FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.		25a. REC'D BY REGISTRAR DATE APR 20 1967	25b. REGISTRAR'S SIGNATURE J Charles Judge

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05242

05240

1 PLACE OF DEATH a. COUNTY <u>Harrison</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. tut. on Res. dence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harrison</u>	
b. CITY OR TOWN (If outside corporate l'mts, write RURAL and give nearest town) <u>Harwood-Grace</u>		c. LENGTH OF STAY IN b. <u>Atedeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dea Harrison Memorial Hospital</u>		e. STREET ADDRESS <u>Herald Rock's Road</u>	
3 NAME OF DECEASED (Type or print) <u>Thomas E Walker</u>		4 DATE OF DEATH <u>April 21</u> 19 <u>67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 28-1930</u>
9 AGE (In years last birthday) <u>36</u> Yrs		10 IF UNDER 1 YEAR Months Days 11 IF UNDER 24 HRS Hours Min	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>G.D. Shind</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Communt</u>	
10c PLACE OF BIRTH <u>W. Va.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Robert E. Walker</u>		14 MOTHER'S MAIDEN NAME <u>Virginia Burton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>unk.</u>	
17 INFORMANT <u>Chapman Funeral Home, Huntington W. Va.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Exsanguination due to laceration</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Neck vessels</u>			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto Accident</u>	
20c TIME OF INJURY Month, Day, Year <u>4-21-67</u> Hour <u>2:30</u> P.M.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resu ted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dorrell C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <u>Be/A i</u> DATE SIGNED <u>4-21-67</u>	
EXAMINER'S NAME (Type) <u>Geryd C Palmer M.D.</u>		DEPUTY MED. CAL EXAMINER <u>4-21-67</u> Address (Street, city, town or county)	
23a BURIAL, CREMATION, OR OTHER DISPOSAL <u>Funeral</u>	23b DATE THEREOF <u>4/24/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>?</u>	23d LOCATION (City or Town) (County) (State) <u>Huntington W. Va.</u>
24 FUNERAL DIRECTOR <u>Conway & Son, Harwood-Grace, Md.</u>		25a REC'D BY REGISTRAR <u>APR 25 1967</u>	
ADDRESS		25b REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05243

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05241

1 PLACE OF DEATH a COUNTY HARFORD MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Res. before admission) a STATE New Jersey b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD COUNTY JAIL		d STREET ADDRESS 70 Vine Street	
3 NAME OF DECEASED (Type or print) EVERETT R. WALLS		4 DATE OF DEATH Month April Day 17 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Unknown
9 AGE (in years lost birthday) 41 yrs		10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) ?	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Unknown	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Unknown	
14 MOTHER'S M.A.DEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Caril-Padgett Funeral Home 208 E. Commerce St. Bridgeton, N.J.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia by hanging DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (Partial)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18) Hanged self in jail	
20c TIME OF INJURY Month Day, Year Hour a.m. 4-17 19 67 p.m.		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) jail (Partial)		20f (City or town) (County) (State) HARFORD, MD.	
21. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED April 17, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		23a REC'D BY REGISTRAR Wm. Cook-Brooks Inc. Baltimore, Md. 21202	
23b DATE THEREOF 4/18/67		23c NAME OF CEMETERY OR CREMATORY Center Grove Meth.	
23d LOCATION (City or town) (County) (State) Cumberland, N. J.		23e REGISTRAR'S SIGNATURE Charles Judge	
24 BURIAL, CREMATION, REMOVAL (Specify) Removal		25a REC'D BY REGISTRAR APR 24 1967	
25b REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05244
CERTIFICATE OF DEATH

05242

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> c. LENGTH OF STAY IN 1b <u>Today</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Mem. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> d. STREET ADDRESS <u>612 Bourbon St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Boula H. Elizabeth</u>	Middle <u>Walter</u>	Last <u>Walter</u>	4. DATE OF DEATH <u>April 28 1967</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27-1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (in years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Havre de Grace, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Walter M. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Sarah McCall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Edmond Walter</u>		Address <u>612 Bourbon St. Havre de Grace, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Old rheumatic and arteriosclerotic</u> DUE TO (c) <u>Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6 month.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Saddle Shaped thrombosis of abdominal + iliac artery</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/8</u> , 19 <u>67</u> , to <u>4/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/28/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>5/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	23d. LOCATION (City, town or county) (State) <u>Havre de Grace Md</u>
24. FUNERAL DIRECTOR <u>Pruntyth Jm</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

02888

02888



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05245 CERTIFICATE OF DEATH 05243

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN	
c. LENGTH OF STAY IN 1b 15 YRS		d. STREET ADDRESS 126 CARROLL AVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 126 CARROLL AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOTTIE MAGROW WORTHINGTON		4. DATE OF DEATH APRIL 29 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 13, 1883
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (County & State, or foreign country) MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES C. BOWMAN		14. MOTHER'S MAIDEN NAME LUCY G. ORRELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-10-3376-D	
17. INFORMANT Mr. Lucy Virginia McPhail, Aberdeen, MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 446X DUE TO Azotemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Anuria DUE TO Nephrosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 3 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 1950 Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-28-67 to 4-29-67 , that (I) (we) last saw the deceased alive on 4-28-67 , and that death occurred at 2:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE P. Bowman		22b. DATE SIGNED 5-1-67	
22c. PHYSICIAN'S NAME (Type or print) P. Bowman M.D.		22d. ADDRESS 8 Law St. Aberdeen, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 2, 1967	
23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		23d. LOCATION (City, town or county) (State) HAVRE DE GRACE, MD	
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		25a. REC'D BY REGISTRAR 5-2-1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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